La Loma
9 Month Well Child **Date: _____**

Name:_____ DOB:_____ Age:_____

Medications:		
Is your child on any medications?	YES	NO
If Yes, Please List:		
Allergies:		
Does your child have any allergies to medications?	YES	NO
Sensory:		
Vision:		
Does your child appear to be able to see well?	YES	NO
Hearing/Speech:		
Does your child appear to be able to hear? E.g. Startles to loud sounds, responds to your voice, etc..	YES	NO
Development:		
Does your child respond to his/her own name?	YES	NO
Does your child understand a few words? E.g. "No-No" "Bye-Bye"	YES	NO
Does your child say "mama" or "dada" (Doesn't mean you, just the words) yet?	YES	NO
Does your child crawl?	YES	NO
Does your child sit by themselves?	YES	NO
Can your child feed himself or herself a cracker?	YES	NO
Can your child bang two toys together?	YES	NO
Does your child pick up things in a sweeping motion with the hand?	YES	NO
Nutrition: Is your child breastfeeding, on formula? [] Breastmilk [] Formula		
Breastfeeding: How many minutes each breast _____? How often approximately? Every _____ Hours?		
Formula: What formula? _____ How many ounces approximately? _____ every _____ hours		
Is your baby on any sold foods? [] YES [] NO If yes, what food? _____		
Is your child on any supplements? E.g. Fluoride, Vitamins, or Iron	YES	NO

Do you have any concerns regarding your child? []NO [] YES (Explain Below)

Signed_____ Printed Name_____
Relationship to Patient? _____ Date_____
Reviewed with Above_____

La Loma Internal Medicine and Pediatrics

Child COMPREHENSIVE REVIEW OF SYSTEMS

Instructions: Answer yes if the following problems are CURRENT, FREQUENT or BOTHERSOME for your child. Explain all yes answers at the end of the last page.

GENERAL: **Date:** _____

When was your child's last Well Child Check?	Date	
Has your child had a recent UNEXPLAINED loss of weight?	YES	NO
Does your child have a fever?	YES	NO
Does your child have excessive fatigue?	YES	NO
Does your child have an acceptable appetite?	YES	NO

EARS, EYES, NOSE, THROAT:

Does your child have any drainage from eyes?	YES	NO
Does your child have any redness or irritation in eyes?	YES	NO
Does your child complain of itchy watery eyes?	YES	NO
Does your child have Nasal Congestion?	YES	NO
Does your child have frequent runny noses?	YES	NO
Does your child suffer from frequent bloody noses? If so, how many per week?	YES	NO

PULMONARY/ LUNGS:

Is your child frequently short of breath? (If yes, AT REST or WITH ACTIVITY)	YES	NO
Does your child cough most days?	YES	NO
Does your child cough up blood?	YES	NO
Has your child had a continuous cough for longer than two to three months?	YES	NO
Does your child Wheeze?	YES	NO

CARDIOVASCULAR/HEART:

Does your child seem to have a racing heart?	YES	NO
Does your child's extremities swell?	YES	NO
Does your child have trouble breathing while lying flat?	YES	NO
Does your child sweat excessively during feedings?	YES	NO
Does your child turn blue around the mouth or have rapid breathing during feedings?	YES	NO

PATIENT NAME: _____

DOB: _____

Date: _____

GASTROINTESTINAL/STOMACH, INTESTINES, LIVER GALLBLADDER:

Does your child complain OFTEN of stomach pains?	YES	NO
Does your child have frequent vomiting?	YES	NO
Does your child have frequent diarrhea?	YES	NO
Does your child have bright red blood in stools?	YES	NO
Does your child have black tarry stools?	YES	NO
Does your child have frequent constipation?	YES	NO
Does your child have difficulty swallowing?	YES	NO

GENITOURINARY/ GENITALS, KIDNEY, BLADDER, URINATION:

Does your child have several wet diapers in a 24-hour period?	YES	NO
Does your child have any blood in urine?	YES	NO
Does your child urinate more frequently than normal?	YES	NO
Does your child have sores / lesions on genitals?	YES	NO

HEMATOLOGIC (BLOOD)

Does your child have problems with bleeding or a history of hemophilia? (Circle which one)	YES	NO
Does your child have a history of anemia?	YES	NO
Does your child have swollen glands that do not resolve?	YES	NO

ENDOCRINE (GLANDS)

Does your child have problems with excessive thirst?	YES	NO
Does your child have dry brittle hair and nails?	YES	NO

MUSCULOSKELETAL / SKIN

Does your child complain often of joint pain?	YES	NO
Does your child have joints that swell or get red? (Circle which one or both)	YES	NO
Does your child often have a rash?	YES	NO

NEUROPSYCHIATRIC (NERVES, BRAINS)

Does your child appear to move arms and legs normally?	YES	NO

PATIENT NAME: _____

DOB: _____